Original Article

The Behaviour of the low income genocide survivors in case of illnesses: « Case of Kaduha, Cyanika and Mushubi Sectors of Nyamagabe District »

D. Nzeyimana[1,*], M. Nzayirambaho[1], J. Ntakirutimana[2]

[1]University of Rwanda/College of Medicine and Allied Health Sciences, Kigali, Rwanda
[2]Clinical Psychology, University of Rwanda, Kigali, Rwanda

ABSTRACT

Introduction: The study was conducted in, Kaduha, Mushubi and Cyanika Sectors of Nyamagabe district, Rwanda. The purpose of the study was to establish, in case of illnesses, the behavior of the survivors of the Genocide committed against Tutsis in Rwanda in 1994 with low income; and investigate on factors affecting that behavior.
Methods : The research was a cross sectional descriptive survey and was conducted in form of census. Study population were Genocide survivors aged or above 19 year, in low income status. The study tools were self-administered questionnaires. P value was used as proof of significant association between dependent variables and predictors. All variables whose P value ≤ 0.05 were concluded to be significantly associated with behavior towards health care seeking. The significance of the predictors was dealt with at multivariate analysis.
Results: The proportion of seeking health care was found to be 47.9%, and at multivariate analysis the factors significantly associated with seeking health care are possession of health care insurance,P-Value,0.000; health status, P-Value, 0.000; Marital status, P-Value, 0.000; type of residence, P-Value,0.001 and age, P-Value, 0.002.
Discussion: Handling the issue of low proportion of seeking health care among genocide survivors presenting illnesses in Kaduha, Cyanika and Mushubi sectors of Nyamagabe District, much emphasis should be put on widowed genocide survivors, elderly survivors, and survivors living in rural settings. Further emphasis should also be put on access to health care insurance including Community-Based Health care Insurance.
Conclusion : According to this study the Ubudehe categorization results should be reviewed because most of genocide survivors may have been put in wrong economical categories. Most survivors do not have health insurance because they lacked the capacity to pay themselves the required premiums. This may signify that they were put in wrong categories where they were mistakenly believed to be economically well.

Keywords: Genocide - Survivors - Illness - Behavior

RESUME

Présentation : L'étude a été menée à Kaduha, Mushubi et Cyanika secteurs du district de Nyamagabe, au Rwanda. Le but de l'étude était d'établir, en cas de maladies, le comportement des rescapés du génocide perpétré contre les Tutsis au Rwanda en 1994 avec un faible revenu, et d'enquêter sur les facteurs qui influent sur ce comportement.
Méthodes : Cette recherche est une enquête descriptive transversale et a été réalisée sous forme de recensement. Les outils de l'étude étaient questionnaires auto-administrés. La Valeur-P a été utilisée comme preuve d'association significative entre la variable dépendante et les variables indépendantes. Toutes les variables dont la valeur-P ≤ 0,05, ont été conclus à être significativement associée à un comportement de recherche de soins. L'importance des facteurs prédictifs a été traitée avec une analyse multi variée.
Résultats : La proportion de recours aux soins de santé a été jugée 47,9% et à l'analyse multidimensionnelle des facteurs significativement associés à la recherche de soins de santé sont l'âge, la possession de l'assurance pour soins de santé, l'état de santé, l'état matrimonial et le type de résidence.
Discussion: Pour tout intervention à résoudre la question de la faible proportion de recours aux soins de santé chez les survivants du génocide présentant des maladies à Kaduha, Cyanika et Mushubi, l'accent devrait être mis sur les survivants veuves âgées, les survivants qui vivent en milieu rural. Davantage, l'accent devrait également être mis sur l'accès à l'assurance pour soins de santé, y compris Mutuelle de Sante.
Conclusion: Selon cette étude les résultats de la catégorisation d'Ubudehe devraient être révisés parce que la plupart des rescapés du génocide ont pu être mis en catégories économiques erronées. La plupart des survivants n'ont pas d'assurance de santé parce qu'ils n'avaient pas la capacité de se payer les contributions nécessaires.

Mots Clés: Génocide - Survivants - Maladie - Comportement

INTRODUCTION

Background of the Study

Genocide has scarred human societies since Antiquity. In the modern era, genocide has been a global phenomenon: from massacres in colonial America, Africa, and Australia to the Holocaust of European Jewry and mass death in Maoist China.
The Genocide committed against Rwandan Tutsis in 1994 was a truly traumatic and horrifying event. It was one of the most brutal acts of murder ever committed. Over

*Correspondence to: David Nzeyimana
University of Rwanda/College of Medicine and Allied Health Sciences
P.O. Box 5229 Kigali, Rwanda
Phone: (+250)788687196
E-mail: nzerudi@yahoo.fr

the course of 100 days from April 6 to July 16 1994, an estimated 800,000 to 1 million Tutsis and some moderate Hutus were slaughtered in the Rwandan genocide. A recent report has estimated the number to be close to 2 million (UN, 2007)

During this period of terrible slaughter, more than 6 men, women and children were murdered every minute of every hour of every day. This brutally efficient killing was maintained for more than 3 months. There are between 300,000 to 400,000 survivors of the genocide. Between 250,000 and 500,000 women were raped during the 100 days of genocide (MINALOC, 2007). Up to 20,000 children were born to women as a result of rape (Amnesty International, 2004). More than 67% of women who were raped in 1994 during the genocide were infected with HIV and AIDS (Foundation Rwanda, 2008). In many cases, this resulted from a systematic and planned use of rape by HIV+ men as a weapon of genocide. There are 10 times as many widows than widowers – almost 50,000 widows of the genocide (Amnesty International, 2004).

Nearly 100,000 survivors are aged between 14 and 21, of which 60,000 are categorized as very vulnerable (MINALOC, 2007). Seventy five thousands of survivors were orphaned as a result of the genocide. Of those that survived the genocide over half the children stopped their schooling, because of poverty 40,000 survivors are still without shelter, many whose homes were destroyed in the genocide (UN, 2004). Seven in Ten survivors earn a monthly income of less than 5000 Rwandan Francs (Equivalent to eight American Dollars (MINALOC, 2007). Due to the highest cruelty in which the genocide was committed, genocide survivors still need high special humanitarian services, of those including specialized health care services.

As reported to The National Parliament on the 16th July 2013 by Dr HABUMUREMYI P.D, the Rwanda Prime Minister, Thirteen social and economical programs were initiated in order to ensure that all poor and vulnerable people are guaranteed a minimum income and access to core public services, those who can work are provided with the means of escaping poverty. Thus increasing numbers of people are able to access risk sharing mechanisms that protect them from crisis and shocks. Genocide survivors are beneficiaries of those programs among other Rwandan citizens living in extreme poverty. Of these, there is Ubudehe program, which is the traditional Rwandan practice and cultural value of working together to solve problems. This program was started in 2001 as one of mechanisms meant to uplift the welfare of vulnerable people (MINALOC, 2011). Up to now 10,216 UBUDEHE projects are being implemented in 15 districts across the country. To identify people who need immediate support, UBUDEHE program identified local categories of poverty in Rwanda. Six categories were recognized. The first category comprises those in abject poverty locally referred to as 'Abatindi Nyakujya', own no property, live on begging and help from others, and consider it lucky if they died. The second category, is the very poor and these have no house, live on poor diet which they can afford with difficulty, work every day for others for their survival, have tattered clothes, own no

portion of land, and do not own cattle. The third category is called the poor. These depend on food deficit in nutrients, own a small portion of land, have low production and their children cannot afford secondary education.

The fourth category comprises the resourceful poor who own some land, cattle, and bicycle, have average production, their children can afford secondary education, and have less difficulties in accessing health care. In the fifth category lie the food rich people who basically own big lands, eat balanced food diets and live decent houses. They employ others, own cattle, and their children easily afford university education. The sixth category is the money rich, who comprise of people with money in banks, receive bank loans, own a beautiful house, a car, cattle, fertile lands, sufficient food and are permanent employers. Generally, according to the Ministry of Finance (MINECOFIN), 2013, the Extreme poverty was reduced from 36% to 24% over 2006-2011 and the Gross Domestic Product (GDP) per capita was $644 in 2012. This implies that Rwanda falls under low income country -living on $1,035 or less as according to World Bank, 2013. It may appear that most Rwandans fall under first four categories. However, the genocide has increased the vulnerability of survivors such that they live under poverty line compared to other Rwandans, therefore most of them if not all belong to the first four categories as well.

FARG was established in 1998 by the Government of Rwanda to support genocide survivors. It is entirely supported by the Government Rwanda (GoR) and its budget is 6% of annual domestic income of the state ordinary budget and other sources/contributions as identified by the Law. Since its inception, 104,877,924,820FRWs were spent on Education, Health, Shelter, Social Assistance & Income generating projects with 20% spent on Health (FARG Report, 2012).

Health Care system in Rwanda

Considering the low purchasing power of the majority of Rwandan population, the paying of health care system has resulted in a low proportion of seeking health services. For instance, in 1998 the rate of utilization of health services was 27%, whereas it was 23% in 1993.

Probably this proportion was significantly lower for socio-economically low groups including orphans, People living with HIV/AIDS, the indigent and the poor population. Therefore, it means that the majority of population was not able to seek health care in case of illness. In such situation, the country efforts to reduce poverty through the increase in production would be nothing since if no health, no work is possible. Thus, bad health status of population would contribute to maintain the population in poverty. To break this vicious circle, the country authorities preferred the establishment of "health insurance" as true approach to access, financially, for the entire population, to health care. This allows him to contribute effectively to the increase in production, and hope for a sustainable socio-economic development. Among health insurance schemes, Community Based Health Insurance was established in 2004, and it was revised in 2010.

In order to increase equity and strengthen the financing of the Community Based Health Insurance (CBHI) System

in Rwanda and raising domestic resources and reduces dependence on external financing, it has consequently been decided to introduce a system of stratification by dividing members into three categories based on Ubudehe criteria. The lowest contribution group comprises the first and second Ubudehe category. The middle contribution group consists of the third and fourth Ubudehe category, and the highest contribution group consists of the fifth and sixth Ubudehe category. For CBHI contribution group 1, an annual premium of RWF 2000 is to be paid. As this group is comprised of the most vulnerable and poor, it is envisaged that their contributions must be paid by a third party, either the GoR or development partners. Contribution group 2 is expected to pay RWF 3000, and group 3 is to pay RWF 7000. Furthermore Rwandans, who desire to access premium services, are encouraged to pay 10,000Frw or more (MOH/CBHI Policy, 2010)

Pre-Hospital care system has been also established whereby each district hospital has got at least three functional ambulances as an approach to geographically access the health care by the population (RHMIS, 2009). Moreover, the Performance Based Financing Program has been implemented to encourage the health services providers to offer clients with the minimum package of activities required at the health centres level, the complementary package of activities and the referral package required at the hospitals level, but quality packages. Thus, the implementation of three programs, Community Health Insurance, Pre-hospital care and the PBF has as result the increase of the health services utilization by the beneficiary population, and probably, an improvement of the quality care. The current geographical accessibility rate is 77% (RHMIS, 2011) meaning that 23% of populations walk more than 1 hour for accessing the health facilities and in addition each district hospital has three well functioning ambulances (MOH report, 2012). Total population covered by health insurance scheme is 96%. The proportion of patients seeking health care services at clinic has steadily increased with 65% in 2001 (DHS, 2005) and 95% in 2009 (RHMIS, 2009). Considering this proportion, the result is satisfactory because according to the WHO, in rural areas the proportion of seeking health care should be equal to or above 60% (WHO, 1978). However, despite all efforts of the GoR since the genocide was stopped in on the 19th of July 1994, FARG still facing challenges including ever increasing number of beneficiaries in all sectors; Sometimes wrong beneficiaries and leave out real needy ones; Students who drop out after secondary, Health cases unknown/silent about it, Socially supported versus income generating projects.

Some reports on genocide survivors' association point out that Programs that continue to address the trauma of genocide and the holistic development and healing of individuals are largely absent (AVEGA AGAHOZO, 2012).

Genocide consequences differ region by region depending the manner in which atrocities were inflicted during the genocide. In southern province particularly in Nyamagabe district, the genocide was stopped very lately such that killers have had maximum time to commit all kind of atrocities. Dr NZEYIMANA Bonaventure, who was in charge of public health facilities at Ministry of Health-Rwanda (MOH) said in a televised show of October 14, 2012 that since low income genocide survivors are experiencing very complicated health problems among the patients who come to seek for health care services at health facilities as a result of genocide , the Ministry of Health in conjunction with FARG and other local NGOs assisting survivors are considering community outreach programs to identify all survivors who need specialized health care services so as to assist them with proper medication programs. So the question is at which extent the health problems of low income genocide survivors are currently solved?

OUR OBJECTIVES

1. To understand the behavior of the genocide survivors with low income in case of illnesses.
2. Establish the magnitude at which the genocide survivors with low income and with disease condition seek health care.
3. Identify the factors that influence seeking health care services among low income genocide survivors;

METHODS

THE STUDY SITE

The study was conducted in Cyanika, Kaduha and Mushubi sectors located in Nyamagabe District, Southern Province, Rwanda. Nyamagabe district has got 23 health facilities including two district hospitals. Each Administrative Sector in Nyamagabe District has got at least one health center. This District has indigents estimated at 35, 69%. The subscription for mutual health insurance scheme is still low. The research was conducted on the behavior towards health care in case of illnesses on determination of factors influencing that behavior.

This chapter describes the research design, gives a brief overview about the population and sampling procedures with inclusion and exclusion criteria, as well as, the research instruments. It shows how the validity and the reliability of the research instruments were controlled, and how data were gathered, managed and analyzed.

Research Design

This study was a cross sectional descriptive survey of Genocide survivors in low income status-comprising the first four UBUDEHE categories. This study was a census in nature, as all eligible persons were included in the study and all eligible candidates had automatic chance to participate in the study. Quantitative strategies of data collection were used by direct administration of questionnaires to the respondents.

Study population

Study population are genocide survivors aged equal or above 19 years with low income capacities based on

the statistics as given out by UBUDEHE program of the Ministry of the Local Government. We collaborated with the district authorities in order to get access to the data base of all the district genocide survivors .The data base was compared with the data base of UBUDEHE Program in first four categories to ensure we have the real study population. The population was divided into four age groups starting with 19 years as the lower level because we believe that the children who were born during genocide were 19 years old.

Sample and Sampling Techniques

We got the list of genocide survivors living in Nyamagabe district. In addition we sought the access to the ubudahe database of Nyamagabe District.

In comparing the list of genocide survivors and Ubudehe database in the first four categories, we found that a big number of study population (488 persons representing 82% of the study population) were coming from Cyanika, Kaduha and Mushubi Sectors, hence the choice of these three sectors. It was an exhaustive sampling with all 488 persons being admitted to the study

Table 1: The number of genocide survivors belonging to the first four
UBUDEHE   categories

Sector	Male	Female	Total
Cyanika	21	87	108
Kaduha	35	97	132
Mushubi	45	203	248
Total	**101**	**387**	**488**

(Data obtained from the FARG office, Nyamagabe district, December 2012)

Research Instruments

To carry out this study, a self-administered questionnaire was used to collect information from the participants. Handling reliability ensures the degree of consistency and stability; hence, it involved examining several times the study instruments on relevance, clarity and ambiguity of items. To achieve this, a pre-test study was conducted on 31 genocide survivors with low income from another sector called Tare I (not included in the sample) in Nyamagabe district.

Data Collection Procedure

After the approval of the study proposal by the National University of Rwanda School of Public Health, the letter of permission to do the study was provided by the Director of School of Public Health. Likewise, the permission to carry out the study in Nyamagabe district was sought from District Mayor through the Secretary Executive. After receiving favorable feedback of the request, Executive Secretary connected me with the Officer in charge of genocide survivors' social welfare. The latter gave us the list of genocide survivors living in Nyamagabe District. Our research assistant went with questionnaire in Cyanika, Kaduha and Mushubi Sectors to collect data. It's important to mention that the Research Assistant

was trained before data collection. Self-administered questionnaire was anonymously and independently filled. For illiterate, questionnaire-guided interview was used by the trained research assistant who, on daily basis, deals with genocide survivors in his actual professional capacity. This approach was preferred because it gave privacy and independency to the participants and encouraged them to willingly reveal whether or not they had ever been at clinic to seek health care services in case of illnesses. They were encouraged to answer all questions as honestly as possible and do so privately. Data collection took place from the 3rd of May 2013 up to the 21st of May 2014.

They were assured of total anonymity and complete confidentiality. After filling the forms, the researcher with his research assistants collected all forms from all participants.

For ethical consideration, prior to the distribution of the study guides, the study participants were explained the study. During these explanations, the participants were assured confidentiality where anonymity in filling questionnaire is the most important tool to ensure the confidentiality. The study participants were informed that the participation in the study was a voluntary activity and no cost associated with participation. A consent form was provided to the respondent and to ensure the willing acceptability of the respondent she/he had to sign on the consent form before filling the questionnaire.

To reach the respondents in the community we took advantage of the meetings which were being organized by the officials in charge social affairs in sectors intended for all Genocide survivors who were put in group one and group two of CBHI and categorized in the first four categories of Ubudehe program. For those missing at the meeting, the research assistant went to see them house by house in their community.

Data analysis

The first objective was addressed whereby proportion of seeking health care at clinic in genocide survivors with low income was determined using the following formula:
The proportion of seeking health care= NSWCT/TPGS

NSWCT=Number of survivors in the first four Ubudehe categories who ever went to clinic for treatment of illnesses during the last two months.
TPDS=Total genocide survivors in the first four Ubudehe categories who got sick during the last two months.
To address the second objective, descriptive statistics were generated through SPSS 16.0 version to describe attributes of the study subjects. Cross-tabulation of each of the independent variables with dependent variable was performed at bivariate analysis one at a time. Then, a multivariate analysis of independent variable that survived at bivariate analysis was performed. The odds ratio (OR) at 95% confidential interval (CI) where possible and p-value were obtained. P values at this stage helped to identify important association.

RESULTS

This chapter presents the findings in relation to the

objectives of the study. After sorting out poorly filled questionnaires which were half of the total questionnaires, 244 well-filled and completed questionnaires remained for analysis. Therefore, data from 244 questionnaires were entered into the computer for analysis. The results are presented in this section in form of percentages, tables, odds ratio and P values.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS

The table 2: The general and socio-demographic characteristics of the study subjects

Variable	Frequency	Percent
Age (years)		
Aged 19 till 24 years	14	5.7
Aged 25 till 34 years	34	13.9
Aged 35 till 49 years	70	28.7
Aged 50 and above	126	51.6
Sex		
Male	35	14.3
Female	209	85.7
Marital status		
Not married	192	78.7
Married	52	21.3
Education		
None	87	35.7
Primary	140	57.4
Secondary or Higher	17	7.0
Religious status		
Not affiliated to any religion (traditional)	3	1.2
Affiliated to a religion (Muslims, Christians, etc...)	241	98.8
Profession of the respondent		
Unemployed	212	86.9
Employed (Self employed, employed in public or private sector	32	13.1
Type of residence of the respondent		
Rural	186	76.2
Urban	58	23.8

Overall, 51% of respondents were between 50 and above, the average age is 61 years. Women represented 86% and 14% of men. Married represent 21%, not married including single; the widowed, separated and divorced represented 79%.

The respondents were 86.9% unemployed and 13.1 employed at public or private services or self-employed. 76.2% lived in rural place and 23.8% in urban place. Most of respondents at 98.8% had a religion nomination.

Table 3 shows that 98.7% of the respondents had been sick for the last two months before the date of data collection; and 1.3% had never been sick

Being sick for the last two months	Frequency	Percent
Yes	241	98.7
No	3	1.3

Table 4 reveals that 115 people who got sick for the last two months before the date of data collection went to clinic to seek health care services among 241 patients. This information indicates that the Proportion of seeking health care services among genocide survivors with low income is 47.9% in Cyanika, Kaduha and Mushubi sectors in 2013.

Table 4: Seeking health care services

Ever consulted the health facility (FOSA)	Frequency	Percent
Yes	115	47.9
No	126	52.1

FACTORS INFLUENCING SEEKING HEALTH CARE SERVICES

Financial and geographical accessibility are traditionally known as main factors that determine the utilization of health care services. The table 5 below indicates that 57% of the respondents possess health care insurance and 43% do not. The table reveals that 74.9% walk less than one hour to reach the nearest health facilities and those who walk more than one hour are estimated at 25.1%.

Table 5: Possession of Health care insurance and Time required reaching the nearest health facility

Possession of any Health Insurance	Frequency	Percent
Possess any health care insurance	139	57.0
Don't Possess a health care insurance	105	43.0
Time required to reach the nearest health facility	**Frequency**	**Percent**
Walk Less than 1 hour to reach the nearest FOSA	143	74.9
Walk more than 1 hour to reach the nearest FOSA	48	25.1

Main reasons for not using health care services among genocide survivors with low income
The table 6 below reveals that 23.8% of the subjects failed to consult the Health Facility when they were sick because they lacked health care insurance. Given that the nearest health is too far (over an hour's walk, 0.4% confirmed was unable to go to see a Health professional. The 1.2% failed to go to the clinic because do not trust Health professional can treat them. The 2.9% used medicines available in the community. The 19.3% were not suffering too much. The 2% used traditional medicines. Those who identified other reasons have prevented them from using health care services are 0.8%.

Table 6: Main reasons for not seeking health care services among genocide survivors with low income

Reasons for not going to clinic for treatment	Frequency	Percent
Lack of Health Insurance	58	23.8
The nearest health facility is too far (over an hour's walk)	1	.4
I don't trust Health professional	3	1.2
Use of medicines available in the community	7	2.9
Was not suffering too much	47	19.3
Use of traditional medicine/herbalist	5	2.0
Other	12	0.8

Table 7 below shows reasons for not having the health care insurance to those who failed to go to clinic for treatment where the big number estimated at 93.5% said they do not have capacity to pay the required premiums. Others stated different reasons: 0.9% does not have health care insurance because of administrative difficulties, and 5.6% have got else reasons.

Table 7: Reasons for Not having health insurance to those who failed to go to clinic for treatment

Reasons for NOT having health Insurance	Frequency	Percent
Lack of capacity to pay the required premiums	101	93.5%
Because of some administrative difficulties	1	0.9%
Other reasons	6	5.6%

FACTORS AFFECTING SEEKING HEALTH CARE

1. Seeking health care in case of illness in genocide survivors with low income, according to the socio-demographic characteristics of respondents.
The table 8 below presents the findings about socio-demographic characteristics of the genocide survivors with low income who participated in the study. Descriptive statistics (frequency and percentages), odds ratio (OR) at 95% confidential interval (CI) and P values were used to analyze the objective.

Age

For persons who were equal or higher than 50 years old, 59% were seeking health care and 41% were not. Those who were aged 35 till 49 sought health care at 41%. There is statistical association between the two variables (p = 0.002) because the P-Value is less than 0.05.

Religious status

For people who were adhered to a religion, 48% used health care services and 52% did not. Among our study population 98.3% had reported as having a religion. There is no statistical relationship between two variables since the P-value 0.999 is greater than 0.05.

Marital status

Among people who were not married, 54% had ever been at the clinic to seek health care while 46% did not. In married persons, 24% had ever been at clinic and 76% did not. There is a strong association between two variables as the P-Value 0.000 is less than 0.05.

Sex

IIn males, 30% sought health care at the clinic while 70% did not. Among females, 51% had ever been at clinic for seeking health care when 49% did not. There is significant association between two variables as the observed P-Value=0.033 is less than 0.05. The calculated Odd ratio suggests that females are two times (95% CI: 1-5.2) more likely to seek health care than males.

Education

Among illiterate people, 53% had paid a visit to clinic to seek for health care services while 47% did not. In fairly educated people, 47% sought health care services and 53 did not. In highly educated persons 31% went to clinic and 69% did not. There is not an association between two variables as the observed P-Value 0.141 is greater than 0.05.

Type of residence

Among people living in urban places, 27% sought health care services at clinic and 73 did not. In rural, 57% went to clinic and 43 did not. The observed P-Value is equal 0.001, which means that there is association between the independent variable and the dependent variable. The calculated Odd ratio shows that people living in rural settings were three times (95% CI: 1-7.6) less likely to go to clinic for treatment in case of illness.

Profession

The half of unemployed persons never sought health care services and in the employed persons 34% ever went to clinic for treatment while the remaining did not, yet they were sick. The calculated P-Value shows that there is no association between two variables.

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Table 8: Table summarizing how socio demographic characteristics of the respondents influence seeking the health care services

Baseline P value	Ever went to clinic for treatment during the last 2 months		OR (95% CI)
Characteristics	Yes: (%)	No: (%)	
Age range			2(1.5-
3.2) **0,002***			
Aged 19 till 24 years	3/14 (21.4%)	11/14 (78.6%)	
Aged 25 till 34 years	10/32 (31%)	22/32 (69%)	
Aged 35 till 49	29/70 (41%)	41/70 (59%)	
Aged 50 and above	73/124 (59%)	51/124 (41%)	
Sex			2 (1-5.2)
0.033			
Male	10/33(30%)	23/33 (70%)	
Female	105/207(51%)	102/207(49%)	
Type of residence			3(1.7.6)
0.001*			
Urban	15/55(27%)	40/55(73%)	
Rural	100/185(54%)	85/185(46%)	
Marital status			4(2-7.9)
0.000*			
Not Married	103/189(54%)	86/189(46%)	
Married	12/51(24%)	39/51(76%)	
Education level			1(0.9-2.1)
0.141			
None	46/87(53%)	41/87(47%)	
Primary	64/137(47%)	73/137(53%)	
Secondary or Higher	5/16(31%)	11/16(69%)	
Profession			2(0.87-4)
0.104			
Unemployed	104/208(50%)	104/208(50%)	
Employed	11/32(34%)	21/32(66%)	
Religion			1(0.9-8)
0.999			
Affiliated to a religion	115/237(48%)	122/237(52%)	
Not affiliated to a religion	0/3(0%)	3/3(100%)	

*Statistically significant variable**

2. Seeking health care in case of illness, according to the health status and the accessibility of health care by respondents.
According to the table below, among people who had not heath care insurance 15% ever went to clinic for treatment in case of illnesses and 85% did not. Among those who had insurance 73% went to clinic for treatment while 27% did not. There is a significant association between having health care insurance and seeking health care services. This is enlightened by the calculated P-Value: 0.000 which is less than 0.05. The obtained odd ratio suggests those who did not have health care insurance were 15 times (95% CI: 7.9-29) less likely to go to clinic than those who had got health care insurance. Thus, the utilization of health services was conditioned by the financial capacity to pay for health care, either through health insurance or paying cash.

Among people who walk less than one hour to reach the nearest FOSA 58% paid a visit for treatment to the FOSA and 42% did not. Of those walking more than one hour to reach the nearest FOSA, it is vice-versa.
However with the multivariate analysis there was no statistical association between two variable because P-Value: 0.994 is greater than 0.05. However other

studies confirmed otherwise.
Among the persons who had ever been sick during two months preceding the survey 58% went to clinic, and 42% went nowhere on contrary. There is a strong statistical association between getting sick and going to the nearest clinic for treatment as ascertained by the P-Value of 0.000, which is less than 0.000.

Table 9 summarizing the coverage health care insurance, the geographical accessibility of the health facility and the health status Vis-à-Vis

Baseline P value	Ever went to clinic for treatment during the last 2 months		OR (95% CI)
Characteristics	Yes: (%)	No: (%)	
Possession of health care insurance			15(7.9-29)
0.000*			
Don't possess the health care insurance	16/105 (15%)	89/105(85%)	
Possess the health care insurance	99/135(73%)	36/135(27%)	
Geographical accessibility for FOSA			1(0.5-2
0.994			
Walk Less than 1 hour to reach the nearest FOSA	81/139(58%)	58/139(42%)	
Walk more than 1 hour to reach the nearest FOSA	28/48(58%)	20/48(42%)	
Health status			21(12.3-33)
0.000*			
Ever been sick for the last two months	115/198(58%)	83/198(42%)	
Never been sick for the last 2 months	0/43(0%)	43/43(100%)	

*Statistically significant variable**

DISCUSSION

According to the table 4 the Proportion of seeking health care services among genocide survivors with low income, in case of illnesses is 47.9% in Cyanika, Kaduha and Mushubi sectors in 2013. This proportion is too low when it is compared with 60% which is the rate that is acceptable as the lowest rate by the World Health Organization (WHO, 1978). However, though it would not be wise to compare this result against the utilization rate, it shows a serious health problem among this population as they do not seek health care in case they get sick as human beings. In addition utilization of health care services and seeking health care is a human right that everyone should not be deprived of, whatever the circumstances (Binagwaho, 2009)
Lack of the required premiums to pay for health care insurance was identified as the main reason of not seeking health care for most of the respondents. This may mean that genocide survivors with low income may have been put in the wrong UBUDEHE categories. This is corroborated with many Civil Society Organizations in Rwanda who have suggested the revision of UBUDEHE categorization (The NewTimes June 2, 2013)
According to the results of our study, the females were two times more likely to seek health care in case of illnesses than males. This is in line with the study done by Anderson, 1973, which confirmed that sex and gender have a significant influence on health care utilization

behavior because of its effect on aspects such as need, recognition, and response to symptoms; knowledge of disease; motivation to get well; and access or choice of health services. Other Researchers also have shown that women have a slightly higher rate of utilization than their male counterparts (Hulka & Wheat, 1985).

Level of Education was found not to be affecting the magnitude of seeking health care in Rwandan survivors of genocide committed against Tutsis in 1994 having illnesses. However other studies have shown otherwise, Muller, 1986 discovered that Education and income usually result in higher use of health care, especially preventive visits and clinic visits; however, educated persons experience less acute disease. This discrepancy would require further research.

Age was found to be associated to seeking health care whereby elderly persons seek health care more than younger ones. This is in conformity with the study conducted by Hulka & Wheat, 1985 which found that old persons use health care services more than young people. A recent trend analysis of hospital utilization in Canada revealed that the characteristics of high users of hospital care are those with multiple chronic conditions and elderly persons with multiple chronic conditions and disabilities (Johansen, Nair, & Bond, 1994).

The definition of our population suggests that they are supposed to be living under minimum conditions of life as they have low incomes, therefore mostly being in unemployment status, 86,9% of respondents were found unemployed. There is strong linkage between having a profession and going to look for health care services. Also being employed helps the individual to get money to pay the required premiums for health care insurance.

Possession of health care insurance-financial accessibility strongly was found associated with seeking health care and those who did not possess the health care insurance were 15 times less likely to seek health care at health facility than those who possessed health care insurance. Also this is linked to Ubudehe categories with which people may have mistakenly assumed to have capacity to pay themselves yet they are not in actual sense.

The geographical accessibility was found not to be affecting seeking health care services among our study population. The slight discrepancy between the obtained proportion 74.9% and the national rate 77% (HMIS 2009) may be due to individual differences in estimating times or in one way or another to the monitoring period which was 2 months vis-a-vis twelve months for the utilization rate.

CONCLUSION

This study aimed at establishing the magnitude of seeking health care services in case of illnesses by the genocide survivors with low income and to identify the influencing factors in Mushubi, Cyanika and Kaduha sectors of Nyamagabe District, Southern Province, Rwanda.

The research was a cross sectional descriptive survey and was conducted in three sectors of the District. The study tools were the self-administered questionnaires for literate persons and questionnaire-guided interview for illiterate ones.

After determining the proportion of seeking health care, the related factors were identified through multivariate analysis. Cross-tabulation of each of the independent variables with dependent variable was performed at bivariate analysis one at a time. Then, a multivariate analysis of independent variables that survived the bivariate analysis was performed. Odds ratio (OR) at 95% confidential interval (CI) also were determined where necessary. All variables whose P value $\leq$ 0.05 (level of significance) were concluded to be significantly associated with the dependent variable.

To find out the magnitude of seeking health care services in genocide survivors with low income, the number of genocide survivors (115) who self-reported having been seeking health care in case of illnesses was divided by the total number of genocide survivors with low income who had ever been sick for the last two months preceding the survey multiplied by 100. The proportion was found to be 47.9%. This proportion was found not satisfactory because at least 60% of all people in need of health care should access and utilize it (WH0, 1978)

The investigation on factors influencing the health care services seeking through multivariate analysis, found that age (P-Value=0.002), Possession of health care insurance (P-Value=0.000), health status (P-Value=0.000), Marital status (P-Value=0.000) and type of residence were significantly associated with seeking health care services in Mushubi, Kaduha and Cyanika Sector of Nyamagabe District since their P-Value are less than 0.05.

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